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NOT TO BE PUBLISHED

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(San Joaquin)

LORENZO C. ROGERS et al., Plaintiffs and Appellants, v. SAN JOAQUIN COUNTY et al., Defendants and Respondents.	C069956 (Super. Ct. No. CV032130)

This action for damages arises from a civil detainee's suicide. Plaintiffs, the decedent's parents, sued the entities and persons that housed and cared for their son. They contended defendants violated decedent's substantive due process right under the Fourteenth Amendment to adequate medical care while civilly detained, and his due process right while detained to receive care from properly trained providers. Plaintiffs sought damages for the alleged constitutional violations under section 1983 of title 42, United States Code (section 1983).

The trial court granted summary judgment against plaintiffs' complaint. Plaintiffs' primary claim alleged the attending psychiatrist, in violation of a civil detainee's constitutional right to medical care, did not exercise professional judgment when she determined the decedent was not at severe risk of committing suicide. That decision triggered a lesser level of care than had she determined he was at severe risk. The trial court found the undisputed material facts showed the psychiatrist exercised her professional judgment. The court also found that qualified immunity shielded the defendants sued in their individual capacities from section 1983 liability.[1] The court later denied plaintiffs' motion for retrial.

Plaintiffs challenge the grant of summary judgment and denial of their motion for new trial. We disagree with their contentions and affirm the judgment. We conclude no disputed issues of material fact show the psychiatrist exercised anything other than her professional judgment in caring for the decedent, and any errors the trial court may have committed were harmless or forfeited. We also conclude the trial court did not abuse its discretion when it denied plaintiffs' motion for new trial.

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1 Plaintiffs also alleged defendants violated the Americans with Disabilities Act (42 U.S.C. § 12101 et seq. (the ADA)) and section 504 of the 1973 Rehabilitation Act (29 U.S.C. § 794 (the Rehabilitation Act)) by failing to modify their services to accommodate the decedent's mental disability. The trial court found that plaintiffs had not pursued this cause of action, and it granted summary adjudication against it. Plaintiffs do not challenge on appeal the trial court's judgment against their ADA and the Rehabilitation Act cause of action.

STATEMENT OF UNDISPUTED FACTS

Defendants San Joaquin County and its Department of Mental Health Services operate the San Joaquin County Mental Health Services Psychiatric Health Facility (PHF), an in-patient facility for treating individuals who need intensive therapeutic psychiatric services. Defendant Bruce Hopperstad was the director of the Department of Mental Health Services for San Joaquin County. Defendant Dr. Paramjit Gill is a psychiatrist employed at the PHF.

The PHF houses patients in one of three suites or units. Unit A receives male patients who are at most risk, unit B receives similarly situated female patients, and unit C receives patients transferred there from the other units once they have been stabilized.

The policies of the PHF require the attending psychiatrist to designate a patient's risk of committing suicide. The psychiatrist may choose from three different levels of risk: severe, moderate, and minimal. If the psychiatrist designates a patient as a severe risk of suicide, the policies of the PHF require nurse staffing to be maintained at ratios as low as one staff member to one severe-risk patient for as long as the patient is a severe risk, and for the nurse to be always at arm's length from the patient. If the patient cannot be maintained with that level of nursing and is persistently a danger to himself, he may be placed in restraints and secluded, the PHF's most restrictive behavioral intervention. In contrast, patients designated as moderate risk of suicide are to be observed by a staff member every 15 minutes.

In November 2004, the decedent, Lorenzo Antonio Rogers, was admitted to the PHF under Welfare and Institutions Code section 5150 (section 5150) as a danger to himself. Rogers was confused, anxious, depressed, and suicidal. He also had difficulty remaining in control. Dr. Gill, the attending psychiatrist, placed Rogers on moderate suicide risk and prescribed medication to keep him calm. Rogers stayed at the PHF for five days.

The PHF staff saw Rogers again in December 2004, January 2005, and February 2005. In December 2004, Rogers had violent fits and threw things. He heard voices and thought about a war between good and evil. By February 2005, Rogers reported his medications helped and he had no suicidal thoughts. He still heard voices, but he could ignore them.

On March 19, 2006, Rogers attempted suicide. He stabbed himself in his neck with a serrated knife. While at the San Joaquin General Hospital (County General) for treatment, Rogers was agitated and wanted to leave. He tested positive for cannabinoids and cocaine. The attending physician believed Rogers was a danger to himself, and she placed him on medication and physical restraints to calm him down and prevent him from leaving.

In the early morning hours of March 20, 2006, Shakera Azimi, a crisis worker from the Department of Mental Health Services, interviewed Rogers at County General. She applied to detain Rogers pursuant to section 5150 and transfer him from County General to PHF. The application stated Rogers' family informed County General that Rogers had a history of "depression and PTSD," and he had not been taking his "meds." He was uncooperative, and he had not "contract[ed] for safety."[2] Although he had been agitated, he was then sedated.

Azimi called Denise Stafford, the shift charge psychiatric technician at the PHF that night, and informed her that a patient at County General needed to be admitted to the PHF.[3] Stafford in turn informed Ofelia Tabuyo, a mental health specialist at the PHF,

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[2] A crisis worker interviewing a suicidal patient regularly attempts to get the patient to contract for his safety. Getting a patient to contract for his safety means obtaining a verbal agreement that the patient will not hurt himself.

[3] As the shift charge, Stafford was responsible for supervising the other mental health workers and psychiatric technicians, admitting patients, answering phones, and carrying out doctor's orders.

that Azimi was bringing a new patient in, and she assigned Tabuyo to process the admission. Tabuyo did so, with some discrepancies to be discussed later.

After Rogers arrived around 2:00 a.m., Tabuyo asked him how he was doing. Rogers said he did not feel good. Their meeting lasted approximately 10 to 15 minutes. Rogers refused to sign legal papers involved in the process. At the end of the meeting, Tabuyo called Stafford to say Rogers needed rest. In her assessment notes, Tabuyo wrote that Rogers appeared to be sedated. Following Stafford's instructions, Tabuyo wrote Rogers was "on moderate suicide precaution due to stabbing himself."

It was Stafford's responsibility as shift charge to determine whether to place someone on a 15-minute watch until staff received orders from the doctor. Although she could not specifically recall making that decision for Rogers, she would have done so as the shift charge that night.

Sometime between 2:15 a.m. and 2:45 a.m., Stafford called the on-call psychiatrist, Dr. Robert Hart, to relay information about Rogers and receive the doctor's orders. Stafford told Dr. Hart that, among other things, Rogers said he was not going to hurt himself. Dr. Hart ordered Stafford to admit Rogers under section 5150 and place him in unit A. He placed Rogers on moderate suicide risk. He directed his physical activity be unrestricted, i.e., that Rogers not be kept in restraints. He also ordered Stafford to give Rogers medication.

Stafford did not recall asking Rogers to contract for his safety, but if he would not have orally contracted, she would have noted that in the medical record. His medical record contains no such notations. Tabuyo did not attempt to get Rogers to contract for his safety. However, she observed Rogers wanting to go to bed, and, in her opinion, that was contracting for safety. She wrote on a form that Rogers was unable to contract for his safety due to his mental state, but because he was cooperative in the admission process, she believed he in effect contracted for safety.

Tabuyo personally observed Rogers resting at 4:15, 4:30, 4:45, 5:00, and 5:15 a.m. Another staff member, Roy Bokerman, checked on Rogers at 5:30, 5:45, and 6:00 a.m., and noted that Rogers was resting. Tabuyo noted Rogers was pacing at 6:15, and then, at 6:30 and 6:45 a.m., Tabuyo noted that Rogers was resting.

At 8:30 a.m., Janet Briscoe, the assistant nursing manager, performed Rogers' initial medical assessment. Rogers was ambulatory, denied being in pain, and denied having any other medical problems. He was depressed but responsive. Initially, he responded slowly, but then improved. He admitted to cocaine and marijuana use. He told Briscoe he did not refill his prescription medication, and that voices told him to cut his neck. He stated he was still sad from being kicked out of the military for methamphetamine use, and now he was stuck with voices.

Dr. Gill, the same psychiatrist who treated Rogers in 2004, was Rogers' treating psychiatrist the morning of March 20, 2006. Before meeting with Rogers, Dr. Gill reviewed records from Rogers' previous stay at the PHF. She reviewed the medical records provided by County General and the section 5150 application form. She also reviewed Dr. Hart's orders, Tabuyo's progress notes, and Briscoe's progress notes.

Dr. Gill met with Rogers at about 9:30 a.m. for approximately 30 minutes. Rogers said he stabbed himself because he was having visual and auditory hallucinations. The voices were "talking him down," or, in other words, being derogatory. At the time of the interview, Rogers was still hearing voices, but he said the voices were not commanding him to do anything. He was not experiencing visual hallucinations. Dr. Gill asked him if he was willing to contract that he would not harm himself. He denied having any suicidal ideas. Dr. Gill testified his response was a contract for safety.

Dr. Gill ordered Rogers to take risperidone to treat his psychotic symptoms. Dr. Gill also signed and adopted Dr. Hart's order to place Rogers on moderate suicide watch. She did so based upon the information she had reviewed before meeting with Rogers and

the information she received from him during the interview. At this point, the order to place Rogers on moderate suicide watch became her order.

Dr. Gill was aware of an unwritten understanding that placing a patient on moderate suicide risk was a "fall-back" position when not enough patient information was known. However, that was not her fall-back position when she interviewed Rogers. She decided the patient's suicide risk "according to the patient." The fall-back position had existed for a long time, and Dr. Gill stated it worked fine most of the time, especially when staff did not know the patient. However, when she was the attending psychiatrist evaluating the patient, she would determine the patient's suicide risk based on the patient's conditions, not any fall-back policy.

The PHF mental health specialists checked on Rogers every 15 minutes. They reported that Rogers on each check was either sitting, resting, or eating. At 2:30 p.m., Rogers informed a staff member he was not thinking about committing suicide. At 3:00 p.m., Rogers was sitting, quiet, and watching television. He appeared sad. However, at the next 15-minute check, Rogers did not respond when the staff worker called his name. The worker found Rogers hanging from a ceiling exhaust fan in a bathroom.

Paramedics transported Rogers to a hospital, where he died five days later.

The California Department of Mental Health investigated the incident. It found the PHF staff had complied with governing regulations in its treatment of Rogers and its handling of the incident.

DISCUSSION

On appeal, plaintiffs contend the trial court erred in granting summary judgment against them and denying their motion for new trial, based on the following grounds:

1. Defendants failed to satisfy their burden of production and the court improperly overruled plaintiffs' objection to defendants' evidence.

2. The trial court erred in granting summary adjudication against plaintiffs' section 1983 causes of action because (a) it applied the wrong standard of inquiry;

(b) disputed issues of material fact exist, (c) defendants Dr. Gill and Bruce Hopperstad are not entitled to qualified immunity; and (d) the court wrongfully weighed evidence.

3. The trial court erred in denying plaintiffs' motion for new trial because (a) it improperly struck a supporting declaration and its evidence; (b) plaintiffs introduced newly discovered evidence; and (c) the court and defendants committed irregularities and errors of law.

We address, and reject, each of plaintiffs' contentions.

I

The Burden of Production and Grant of Reconsideration

Plaintiffs initially allege the trial court erred by finding the defendants had satisfied their burden of production in moving for summary judgment and by overruling on reconsideration plaintiffs' objection to most of the evidence the defendants presented. We conclude the trial court did not commit error on these issues.

A. *Additional background information*

With their motion for summary judgment, defendants submitted their documentary evidence under the declaration of Jim Garrett, the PHF's director at the time of the motion.[4] Garrett had served as the PHF's director since 2007, beginning his employment a year or so after Rogers died. He submitted with his declaration copies of Rogers' medical records and reports, and copies of policies maintained by the PHF at the time of Rogers' death. Even though Garrett was not employed by the PHF at the time of Rogers' death, he declared "[t]he facts" stated in his declaration were true and correct based upon his "own personal knowledge," and that he could competently testify concerning them.

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[4] For the reader's clarification, Garrett, who was not named as a party, was the director of the PHF. Defendant Hopperstad was the director of the County Department of Mental Health Services, which operated the PHF.

Before filing their opposition to defendants' motion, plaintiffs took the depositions of 10 witnesses. As part of their opposition, plaintiffs submitted the complete transcripts of each of these depositions under the declaration of their attorney. Plaintiffs also submitted all of the medical records the defendants had produced in discovery, including each of the documents Garrett had attached to his declaration in support of the motion.

Also as part of opposing the motion for summary judgment, plaintiffs objected to Garrett's declaration and moved to strike it. They argued Garrett was not competent to testify as he lacked personal knowledge of the relevant events.

The trial court sustained plaintiffs' objections to Garrett's declaration, and it denied summary adjudication against plaintiffs' section 1983 claims for lack of evidence. Garrett did not establish he had personal knowledge of the events described in the documents attached to his declaration. He also did not establish he was the PHF's custodian of records.

In response, defendants filed a motion for reconsideration. They contended a new or different circumstance justifying the motion was a revised declaration by Garrett addressing the defects found by the trial court in his earlier declaration. His revised declaration stated he had been, and still was, personally familiar with the documents attached to his earlier declaration, as he had been the person who produced them in response to plaintiffs' document request three years earlier. The documents were kept consistent with the record-keeping policies of the PHF and were in his custody and control. He also was the person most knowledgeable to testify regarding the PHF patient records and policies. Garrett did not resubmit with this second declaration the documents he had attached to his first declaration, but he appears to have incorporated them by reference.

Defendants also argued reconsideration was just because plaintiffs in their opposition relied upon the same documents they sought to exclude from defendants' motion. Plaintiffs offered them as exhibits in the depositions they took after defendants

filed their motion for summary judgment, they referred to them in their opposition papers, and they submitted them into evidence. Defendants claimed plaintiffs thus forfeited all objections to those documents.

The trial court granted defendants' motion for reconsideration. The court offered no reasons for its decision. Ultimately, the court granted defendants' motion for summary judgment, and it specifically overruled plaintiffs' objection to Garrett's declaration.

B. *Analysis*

Plaintiffs contend the trial court erred when it implicitly concluded defendants met their burden of production. Plaintiffs also contend the court erred in granting reconsideration because Garrett, when he submitted his second declaration, still lacked personal knowledge of the documents to which he attested. We disagree.

As the parties moving for summary judgment, defendants bore an initial burden of producing sufficient evidence to make a prima facie showing of the nonexistence of any triable issues of material fact. (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 850.) A prima facie showing is one that is sufficient to support the moving party's position. "No more is called for." (*Id.* at p. 851.)

A plaintiff has no evidentiary burden to oppose a motion for summary judgment until the defendant meets his burden of production. (*Binder v. Aetna Life Ins. Co.* (1999) 75 Cal.App.4th 832, 840.) Nevertheless, plaintiffs here opposed the motion by submitting into evidence each document defendants had submitted under Garrett's declaration, and then some.

Plaintiffs fail to recognize that the deposition transcripts and evidence *they* presented in opposition to the motion cured any evidentiary gaps in the defendants' moving papers. (*Villa v. McFerren* (1995) 35 Cal.App.4th 733, 750-751.) The trial court "must consider all of the papers before it," and it may find that the opposing party's papers, combined with the moving party's papers, present sufficient evidence to shift the

burden of production to the opposing party. (*Id*. at p. 751; Code Civ. Proc., § 437c, subd. (c).)

The trial court made this implicit finding, and it did not abuse its discretion in doing so. When considered as a whole, the evidence before the trial court established defendants' prima facie case.

Plaintiffs contend the trial court abused its discretion by overruling their objections to Garrett's declarations. They argue Garrett continued to lack personal knowledge, and, even if he qualified as a custodian, he failed to establish a foundation or hearsay exception for any of the documents.

Plaintiffs have forfeited their objections to Garrett's declaration and the documents submitted with it. "It is axiomatic that a party who himself offers inadmissible evidence is estopped to assert error in regard thereto. [Citation.]" (*People v. Williams* (1988) 44 Cal.3d 883, 912.) In opposition to the motion for summary judgment, plaintiffs submitted into evidence, and relied upon, the very documents they claim the trial court erroneously admitted. Their submission and reliance on that evidence forfeits any objection they had to its admission under Garrett's declaration.[5]

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[5] In their reply brief, plaintiffs for the first time contend defendants' motion for reconsideration did not satisfy the statutory requirements for granting reconsideration under Code of Civil Procedure section 1008. In their opening brief, plaintiffs argued the trial court improperly granted reconsideration because defendants continued to use Garrett as the declarant for admitting documentary evidence, not because the motion did not meet the statutory requirements. Plaintiffs do not explain why they failed to raise the latter argument in their opening brief. Under such circumstances, we do not address arguments raised in the reply brief for the first time, and the argument is forfeited. (*Julian v. Hartford Underwriters Ins. Co.* (2005) 35 Cal.4th 747, 761, fn. 4.)

In any event, we perceive the court granted reconsideration because, after plaintiffs had submitted their evidence, it had all the relevant evidence before it to rule on the motion for summary judgment. A trial court may reconsider a prior interim order on its own motion, which would have been the better practice. (*Le Francois v. Goel* (2005) 35 Cal.4th 1094, 1108-1109.)

II

Summary Judgment Against Section 1983 Claims

Plaintiffs contend the trial court erred in granting summary judgment against their section 1983 causes of action.[6] They assert (1) the court applied the wrong standard for determining whether defendants violated Rogers' constitutional rights; (2) disputed issues of material fact exist, (3) Dr. Gill and Bruce Hopperstad are not entitled to qualified immunity; and (4) the court wrongfully weighed evidence. We disagree with plaintiffs' arguments. The trial court applied the correct standards, correctly determined plaintiffs failed to establish disputed issues of material fact, correctly found qualified immunity, and did not improperly weigh the evidence.

A. *Standards for finding a violation of constitutional rights*

Plaintiffs allege the trial court analyzed their section 1983 claims under the wrong standard of inquiry. It did not.

"To state a claim under [section] 1983, a plaintiff must allege the violation of a right secured by the Constitution and laws of the United States, and must show that the alleged deprivation was committed by a person acting under color of state law. [Citations.]" (*West v. Atkins* (1988) 487 U.S. 42, 48 [101 L.Ed.2d 40, 48-49].) No one

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Plaintiffs also contend defendants violated Code of Civil Procedure section 437c's procedures governing summary judgment when they attached to declarations in support of the motion for reconsideration portions of the deposition transcripts plaintiffs had submitted in opposition to the motion for summary judgment, and when defendants did not file a revised separate statement of undisputed facts after reconsideration was granted. Error in this regard, if there was any, was harmless when the motion is viewed as one made by the court, and because again the evidence duplicated that submitted by plaintiffs.

[6] For the sake of clarity, we refer to the trial court's order, as the trial court did, as one for summary judgment. The court granted summary adjudication against the two section 1983 causes of action, and it previously granted summary adjudication against plaintiffs' only other cause of action, the ADA and Rehabilitation Act cause of action. It therefore awarded summary judgment.

disputes that defendants acted under color of state law. The pertinent issue is whether defendants violated Rogers' constitutional rights.

A person civilly committed has substantive due process rights to adequate medical care. (*Youngberg v. Romeo* (1982) 457 U.S. 307, 315 [73 L.Ed.2d 28, 36-37] (*Youngberg*).) We apply different standards of inquiry to determine whether a municipality or its employees are liable for violating a civil detainee's rights to medical care. The first standard applies to decisions made by a professional. Reviewed under this standard, a "decision, if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." (*Id*. at p. 323, fns. omitted.) Under this standard, occasionally referred to as the *Youngberg* professional judgment standard (*Ammons v. Washington Dept. of Social and Health Services* (9th Cir. 2011) 648 F.3d 1020, 1027), the Constitution requires only that courts ensure professional judgment was in fact exercised. (*Youngberg, supra,* 457 U.S. at p. 321.)[7]

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[7] "By 'professional' decisionmaker, we mean a person competent, whether by education, training or experience, to make the particular decision at issue. Long-term treatment decisions normally should be made by persons with degrees in medicine or nursing, or with appropriate training in areas such as psychology, physical therapy, or the care and training of the retarded. Of course, day-to-day decisions regarding care—including decisions that must be made without delay—necessarily will be made in many instances by employees without formal training but who are subject to the supervision of qualified persons." (*Youngberg, supra,* 457 U.S. at p. 323, fn. 30.)

In a section 1983 action by a civil detainee against employees of a state mental institution, the appellate court determined the institution's superintendent and assistant superintendent, the plaintiff's attending physician, program coordinator, unit manager, senior resident supervisor, resident supervisor, residential services supervisor, nurses, occupational therapist, special education teacher, and the institution's recreation director were professionals within the meaning of the *Youngberg* professional judgment standard. (*Shaw by Strain v. Strackhouse* (3d Cir. 1990) 920 F.2d 1135, 1147 (*Strackhouse*).)

The second standard for evaluating decisions affecting civil detainees applies to decisions made by persons other than professionals. We review decisions by these personnel under a deliberate indifference standard. (*Strackhouse, supra*, 920 F.2d at p. 1147.) Under this standard, a person is liable for denying a civil detainee needed medical care "only if the person 'knows of and disregards an excessive risk to [detainee] health and safety.' (*Farmer* [*v. Brennan* (1994)] 511 U.S. [825,] 837 [128 L.Ed.2d 825, 811] [(*Farmer*)].) In order to know of the excessive risk, it is not enough that the person merely 'be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, [ ] he must also draw that inference.' ([*Ibid*.]) If a person should have been aware of the risk, but was not, then the person has not violated the [Constitution], no matter how severe the risk. (*Jeffers v. Gomez*, 267 F.3d 895, 914 (9th Cir. 2001).) But if a person is aware of a substantial risk of serious harm, a person may be liable for neglecting a [detainee's] serious medical needs on the basis of either his action or his inaction. (*Farmer*, [*supra*,] 511 U.S. at 842.)" (*Gibson v. County of Washoe* (9th Cir. 2002) 290 F.3d 1175, 1187-1188, fn. omitted, overruled on another ground in *Castro v. County of Los Angeles* (9th. Cir. 2016) 833 F.3d 1060, 1076.)

The third standard applies to plaintiffs' claims against the County and the Department of Mental Health Services. Local government liability under section 1983 cannot be based on respondeat superior. Instead, the government is liable when execution of its policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts the injury. (*Monell v. Department of Social Services* (1978) 436 U.S. 658, 694 [56 L.Ed.2d 611, 638].)

In limited circumstances, the municipal government's decision not to train its employees about their legal duty to avoid violating citizens' rights may also be considered as an official government policy for purposes of section 1983. (*Connick v. Thompson* (2011) 563 U.S. 51 [179 L.Ed.2d 417] (*Connick*).) "A municipality's culpability for a deprivation of rights is at its most tenuous where a claim turns on a

failure to train. [Citation.] To satisfy the statute, a municipality's failure to train its employees in a relevant respect must amount to 'deliberate indifference to the rights of persons with whom the [untrained employees] come into contact. ([*City of Canton v. Harris* (1989) 489 U.S. 378, 388 [103 L.Ed.2d 412] (*Canton*)].) Only then 'can such a shortcoming be properly thought of as a city "policy or custom" that is actionable under [Section] 1983.' (*Id.,* at 389.)

" ' "[D]eliberate indifference" is a stringent standard of fault, requiring proof that a municipal actor disregarded a known or obvious consequence of his action.' [Citation.] Thus, when city policymakers are on actual or constructive notice that a particular omission in their training program causes city employees to violate citizens' constitutional rights, the city may be deemed deliberately indifferent if the policymakers choose to retain that program. [Citation.] The city's ' "policy of inaction" ' in light of notice that its program will cause constitutional violations 'is the functional equivalent of a decision by the city itself to violate the Constitution.' *Canton, supra,* 489 U.S., at 395 [103 L.Ed.2d 412] (O'Connor, J., concurring in part and dissenting in part).)" ' " (*Connick, supra,* 563 U.S. at pp. 61-62.)[8]

However, a local government cannot be held liable under section 1983 if a court determines there was no constitutional violation committed by anyone, even where the government regulation or custom may have wrongly authorized an unconstitutional act. (*City of Los Angeles v. Heller* (1986) 475 U.S. 796, 799 [89 L.Ed.2d 806, 810-811].)

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[8] We note a distinction between the two "deliberate indifference" standards just discussed. To prove deliberate indifference for a section 1983 claim against nonprofessional employees, the plaintiff must establish the employees' subjective knowledge. To prove a municipality's deliberate indifference in failing to train employees, the plaintiff need only establish the municipality's constructive knowledge. (*Baker v. District of Columbia* (2003) 326 F.3d 1302, 1305-1307; see *Castro v. County of Los Angeles, supra,* 833 F.3d at pp. 1076-1077.)

In this case, the trial court applied the correct standard of inquiry to all of plaintiffs' claims under section 1983. The court applied the *Youngberg* professional judgment standard to plaintiffs' claims against Dr. Gill. It applied the deliberate indifference standard to any claims plaintiffs alleged against nonprofessional County employees. It determined whether any constitutional injury was caused by the execution of a County policy or custom by Hopperstad. And it applied the deliberate indifference standard to plaintiffs' claims against the County for failing to train its employees. The court did not err in the standards of inquiry it used.

B. *Disputed issues of material fact*

Plaintiffs' primary contention is that defendants, particularly Dr. Gill, violated Rogers' constitutional rights to adequate medical care and supervision by designating Rogers as a moderate suicide risk instead of a severe suicide risk. Had Dr. Gill designated Rogers as a severe risk requiring one-on-one nurse staffing, he would have been observed by a nurse around the clock at arm's length, and, plaintiffs argue, would thereby have been prevented from hanging himself. The undisputed evidence, however, demonstrates Dr. Gill exercised her professional judgment in designating Rogers as a moderate risk, and that her decision is not such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that she did not base her decision on such judgment.

Before seeing Rogers, Dr. Gill reviewed records from Rogers' 2004 stay at the PHF. She also reviewed the medical records provided by County General and the section 5150 application form. She understood Rogers had attempted suicide by stabbing his neck with a knife. She did not know Rogers had been restrained while at County General. She reviewed Dr. Hart's orders, Ofelia Tabuyo's progress notes, and Janet Briscoe's progress notes before meeting with Rogers.

Dr. Gill met with Rogers at about 9:30 a.m. for approximately 30 minutes. She wrote that Rogers said he stabbed himself because he was having visual and auditory

hallucinations. The voices were "talking him down." At the time of the interview, Rogers was still hearing voices, but he said the voices were not commanding him to do anything. He was not experiencing visual hallucinations and he had no suicidal ideation.

Dr. Gill prescribed medication to treat his psychotic symptoms. Dr. Gill also signed and adopted Dr. Hart's order to place Rogers on moderate suicide watch and not keep him in restraints. She wrote on the order that she signed it at 9:30 a.m., but she stated in her deposition she signed it while she was meeting with Rogers, and did so based upon the information she had reviewed before meeting with him as well as the information she received from him during the interview. At this point, the order to place Rogers on moderate suicide watch became her order.

During her interview with Rogers, Dr. Gill asked if he was willing to contract that he would not harm himself. Rogers denied having any suicidal ideas. Dr. Gill testified his response was a contract for safety. She also informed him what to do if he started to have suicidal ideas.[9]

The PHF's policies governing care of suicidal patients direct the attending psychiatrist to designate a patient's risk of suicide as severe, moderate, or minimal. A patient is at severe risk if he has a recent medically serious suicide attempt and continues

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9 In her admission note and discharge summary, Dr. Gill described her meeting with Rogers as follows: "At the time of the admission the patient was a medium height and built male who looked stated age. Grooming and hygiene were marginal. His mood was anxious and dysphoric with appropriate affect. The patient was cooperative. Some psychomotor retardation was noted. The patient was slow to respond to questions. He denied visual hallucinations. He reported auditory hallucinations which were not command in nature. However, the patient reported feeling distressed with the voices, which were talking about Satan and the devil. The patient denied any delusions. There were no suicidal or homicidal ideas. The patient was alert and oriented X 3 [as to time, place and person]. Concentration and attention were poor. Insight and judgment were impaired. [¶] The patient agreed to take r[i]speridone . . . . When evaluated at 1430 the patient denied suicidal ideas. The patient showered and rested. He was cooperative without any behavior problems."

to express suicidal ideation; engages in impulsive, bizarre behavior coupled with threats of suicide or an unwillingness to agree not to harm himself; or exhibits severe depressive symptoms while expressing suicidal and delusional ideas of guilt. If the patient is at high risk of self-harm or victimization by other patients, the psychiatrist is to designate the patient as a severe risk. A severe-risk patient is to be observed by hospital staff at a ratio of up to one staff per one patient 24 hours a day. In addition, if the severe-risk patient cannot be safely maintained with that level of observation and is persistently a danger to himself, he may be placed in restraints and seclusion.

A patient is at moderate risk of suicide if he is moderately depressed while expressing hopelessness or allusions to "being better off dead." A patient is at minimal risk if he is depressed and in the past has intentionally injured himself, has nondelusional ideas of decreased self-esteem, or sees the future pessimistically.

Dr. Gill was well within her professional judgment to designate Rogers as a moderate risk. It is factually undisputed that at the time Dr. Gill met with Rogers, he was not engaging in any kind of bizarre or impulsive behavior and was not threatening to commit suicide. He was calm and not threatening to run away or to harm himself or others. In fact, he orally contracted for his safety with Dr. Gill, telling her he had no suicidal intentions. Based on these observations, her review of Rogers' medical records, and in accordance with the policy of the PHF, Dr. Gill designated Rogers as a moderate risk. Plaintiffs introduced no evidence showing her designation was so far removed from accepted professional judgment or standard as to show she did not make her decision based on her professional judgment.

Plaintiffs contend disputed material facts show Dr. Gill did not exercise any professional judgment in designating Rogers as a moderate suicide risk. They claim their evidence shows Dr. Gill, instead of exercising professional judgment, (1) relied upon an unofficial and unwritten policy of the PHF requiring all suicidal patients to be designated as moderate risk; (2) unreasonably relied upon Rogers' statements that he was not

suicidal; and (3) unreasonably relied upon earlier records prepared by Tabuyo who falsified her entries. Plaintiffs also contend (4) their expert witness's testimony further established Dr. Gill did not exercise professional judgment by designating Rogers as a moderate risk. They also assert (5) they introduced disputed facts showing the PHF failed to train its personnel. We conclude plaintiffs' evidence does not establish disputed issues of material fact.

1. *Unofficial policy*

Plaintiffs contend the defendants relied upon an unlawful and unofficial policy that directed the PHF staff to designate suicidal patients as moderate risk, regardless of the actual risk the patient posed, so that the PHF could avoid additional costs and responsibilities it would incur if it designated a suicidal patient as a severe risk. Whether such an unofficial policy exists is disputed, but whether Dr. Gill relied upon that policy is not.

Dr. Hart, in his deposition, stated it is the default position of the shift charge to place a person on moderate suicide precaution when a person comes in who is a danger to himself. It was not so much a policy as an unwritten custom. In his opinion, designating a patient as moderate risk affords enough protection in cases where there is no clear indication the person is currently suicidal in order to maintain safety until the assessment proceeds further.

Dr. Gill was aware of an unwritten understanding that placing a patient on moderate suicide risk was a "fall-back" position when not enough patient information was known. However, she testified it was not *her* fall-back position when she interviewed Rogers. She decided Rogers' suicide risk "according to the patient." The fall-back position had existed for a long time, and Dr. Gill stated it worked fine most of the time, especially when the staff did not know the patient. However, when the attending psychiatrist evaluates the patient, she will set the patient's suicide risk based on the patient's actual conditions.

Plaintiffs introduced no evidence contradicting Dr. Gill's testimony that she did not rely upon the unwritten policy or custom when she designated Rogers as a moderate risk. Instead, plaintiffs in effect argue that when all the circumstances in this case are considered, Dr. Gill must have relied upon the unwritten custom. Stafford designated Rogers as moderate risk, and Dr. Hart did the same without reviewing Rogers' medical records. But this case pivots on the actions Dr. Gill took, not Stafford or Dr. Hart. Dr. Gill testified she did not rely upon the unwritten custom, and no facts show she did.

2. *Rogers' statements*

Plaintiffs claim they introduced evidence disputing whether Rogers in fact told Dr. Gill he was not suicidal, or, if he had said so, whether it was reasonable for Dr. Gill to believe him. Neither Tabuyo nor Stafford recorded in Rogers' records he had contracted for safety. And Briscoe reported Rogers was still hearing voices. However, none of these facts oppose Dr. Gill's testimony that at the time she met with Rogers, after Tabuyo, Stafford, and Briscoe had met with him, Rogers denied having suicidal ideation.

Plaintiffs question Dr. Gill for relying on Rogers' statement because he was mentally ill at the time. However, they introduced no evidence showing Dr. Gill's reliance on Rogers' statements substantially departed from professional standards. Dr. Gill also testified she relied upon her personal evaluation of Rogers as well as his statements in order to designate him as a moderate risk.

Plaintiffs accuse Dr. Gill of issuing orders before examining Rogers, and that this somehow shows Rogers did not contract for safety. Dr. Gill issued two orders before examining him. One order directed that the dressing on his neck wound be changed daily and that his sutures be removed in seven to 10 days. The other required Rogers to receive risperidone twice a day. Dr. Gill also signed Dr. Hart's order during her interview with Rogers designating Rogers as a moderate risk. By doing so, she adopted Dr. Hart's order as her own. These orders do not contradict Dr. Gill's testimony that she relied on her

professional judgment to determine Rogers was a moderate risk and that Rogers told her he did not intend to commit suicide.

Plaintiffs claim Dr. Gill contradicted her testimony that Rogers contracted for safety because she signed a document that stated Rogers was a danger to himself due to suicidal ideation. However, plaintiffs never asked Dr. Gill about this document in her deposition. We thus have no evidence of her signature's significance, and we do not even know when she signed it on March 20, 2006.

The document, designated as a "Diagnosis and Problem Assessment," contains a section called the "Problem List." Under the subheading "Problem," the document contains the pre-printed words "Danger to Self." Following these words, a staff member, someone other than Dr. Gill, handwrote "Suicidal ideation." The document does not disclose when on March 20, 2006, or under what circumstances the notation was made.

The evidence we have about this document comes from Janet Briscoe, the nurse who assessed Rogers, and Dr. Hart. Briscoe stated psychiatrists, social workers, and nursing staff used the form to identify patient problems. She signed the form at some point on March 20, 2006, as it related to Rogers' medical problems. We do not know at what time she signed it, but at that time, the handwritten reference to suicidal ideation was not there.

Dr. Hart testified the handwritten notation, made by a social worker trainee and not Dr. Gill, meant Rogers had expressed suicidal ideation at some point in time, possibly prior to admission to the PHF. Dr. Hart stated the notation was recorded in order to justify Rogers' admission into the PHF's expensive and restrictive environment, and he doubted Dr. Gill would have relied upon it.

The document itself supports Dr. Hart's testimony. Dr. Gill signed the document in two places. At the bottom of the document, she affixed her signature and the date, March 20, 2006. However, at the top of the document, she signed that she diagnosed Rogers as having a psychiatric disorder, and that the disorder was present *at admission*.

The document thus indicates the reason why Rogers was committed to the PHF. It does not contradict Dr. Gill's testimony that Rogers contracted for safety when she met with him more than seven hours after he was admitted, nor does it indicate that Dr. Gill did not exercise her professional judgment in believing Rogers was not contemplating suicide when she met with him.

3. *Falsified medical records*

Plaintiffs contend evidence of the PHF personnel falsifying Rogers' medical records that were later reviewed by Dr. Gill indicates she did not exercise her professional judgment in designating Rogers as a moderate risk. We disagree.

The questioned records were prepared by Ofelia Tabuyo. Tabuyo received documents from County General concerning Rogers' section 5150 application by fax at about 1:30 a.m. March 20, and she began entering the information into her computer. About 30 minutes passed, from approximately 1:30 a.m. until 2:00 a.m., from the time Tabuyo began entering this information until Rogers arrived at the PHF.

Also at 1:30 a.m., Tabuyo started recording Rogers' physical status on a 15-minute check form. She wrote he was sitting at 1:30 a.m. and 1:45 a.m., even though he was not at the PHF at those times. She stated the PHF started the 15-minute observations at the time the patient was detained under section 5150, so she filled in those times for Azimi, based on a conversation with her.

Tabuyo also used County General's admission authorization form to complete the PHF's patient-opening form for Rogers. She noted on the patient-opening form and the client information sheet that she completed those documents at 1:30 a.m., which, again, was the same time Azimi signed the admission authorization form at County General. Tabuyo testified at her deposition that she did not actually prepare the documents until 2:00 a.m. She wrote 1:30 a.m. because that was the time Rogers' 72-hour hold under section 5150 began.

Plaintiffs assert these actions by Tabuyo taint the entire process because they allegedly bring into question all of the information Tabuyo compiled on Rogers and, thereby, Dr. Gill's reliance on that information. However, plaintiffs introduced no facts showing the substance of the information Tabuyo input was incorrect, that any other information Tabuyo recorded was compiled incorrectly, or, most significantly, that Dr. Gill relied exclusively on Tabuyo's work to designate Rogers as moderate risk. Dr. Gill unequivocally stated she based her designation of Rogers as a moderate risk primarily on her personal observations and judgment about him. Tabuyo's misstatements as to the time she made her records would not have impacted Dr. Gill's opinion. Tabuyo's actions do not establish that Dr. Gill did not rely upon her professional judgment in making her determination.

4. *Plaintiffs' expert testimony*

Plaintiffs contend their expert witness's testimony established disputed issues of material fact. It did not.

Dr. Pablo Stewart, a professor of psychiatry at the University of California, San Francisco, testified by declaration that, based upon his review of the documentary evidence, any reasonable psychiatric care provider would have designated Rogers as a severe suicide risk. Dr. Stewart stated the PHF staff's designation of Rogers as a moderate suicide risk "was indicative of an indifference to and cavalier treatment of the facts regarding a patient's propensity for self-destructive behavior. This systemic indifference was the direct result of Defendant[s'] policy and procedure to place acutely mentally ill patients on 'moderate suicide' precaution so as to save costs and expenses associated with the treatment of patients who presented with 'severe suicide' risks."

Dr. Stewart opined that based on the facts as he saw them—the attempted suicide, the unofficial policy, Rogers' refusal to contract for safety, his continuing to hear voices, and his continued exhibition of suicidal ideation—Dr. Gill did not follow professional judgment by designating Rogers as a moderate risk.

The trial court disregarded Dr. Stewart's opinion because its conclusions were not supported by the undisputed facts. The court did not abuse its discretion in doing so. Contrary to Dr. Stewart's understanding, undisputed facts showed that Rogers, when he met with Dr. Gill, contracted for his safety and did not exhibit any suicidal ideation. Indeed, there is no evidence Rogers expressed suicide ideation at any time after he arrived at the PHF. He denied wanting to commit suicide when he spoke with Tabuyo and Stafford at 2:00 a.m., with Dr. Gill at 9:30 a.m., and with an unidentified staff member at 2:30 p.m.

Also, contrary to Dr. Stewart's statements, there is no evidence Rogers was designated as a moderate risk in accordance with an unofficial policy in order to save costs. Dr. Gill testified her designation of Rogers as moderate risk was not based on any policy or custom of the PHF requiring her to designate him as moderate risk. Dr. Stewart provided no contrary evidence.

An expert opinion may not be based on assumptions of fact that are without evidentiary support. (*Brown v. Ransweiler* (2009) 171 Cal.App.4th 516, 529.) Because it is based on unsupported facts, Dr. Stewart's declaration fails to establish Dr. Gill did not exercise her professional judgment, and the trial court did not abuse its discretion in disregarding it.

5. *Failure to train*

Plaintiffs contend they introduced facts showing the County implemented the policy requiring all mentally ill patients to be classified as moderate risk no matter their true risk, and it failed to train and supervise its employees on the proper treatment of suicidal patients. Their claim rests solely on the PHF's unwritten custom of designating patients as moderate risk when more information is not known. However, undisputed evidence established Dr. Gill did not rely on that custom. There is thus no evidence any of the County's policies for the PHF's operation or its training in those policies, or its alleged failure to train employees how to properly treat suicidal patients, deprived Rogers

of his constitutional rights. The County cannot be liable where none of its employees named in the action violated Rogers' rights.

In sum, plaintiffs did not introduce any disputed issues of fact material to their section 1983 claims. The undisputed evidence shows Dr. Gill exercised her professional judgment in designating Rogers as a moderate risk. It also shows no one at the PHF acted or implemented a County policy with deliberate indifference towards Rogers' constitutional right to medical care. The trial court correctly granted summary judgment based on a lack of disputed issues of material fact.

C. *Qualified immunity*

Plaintiffs sued Dr. Gill and Department of Mental Health Services director Hopperstad in their individual capacities for violating Rogers' constitutional rights. The trial court determined qualified immunity shielded Dr. Gill from liability, and that there were no factual allegations that Hopperstad was personally involved in the incident or in implementing a policy that deprived Rogers of his constitutional rights. Plaintiffs contend neither individual is entitled to qualified immunity. They are incorrect.

"The doctrine of qualified immunity protects government officials 'from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known.' [Citation.]" (*Pearson v. Callahan* (2009) 555 U.S. 223, 231 [172 L.Ed.2d 565, 573].) When considering a claim of qualified immunity, a court must determine "whether the facts that a plaintiff has alleged . . . make out a violation of a constitutional right," and "whether the right at issue was 'clearly established' at the time of defendant's alleged misconduct." (*Id.* at p. 232.) Qualified immunity shields a government official unless his conduct violated a clearly established constitutional right. (*Ibid.*)

We have determined the PHF staff did not violate Rogers' right to adequate medical care while he was detained at the PHF. Because Dr. Gill's action did not violate a constitutional right she is entitled to qualified immunity. Hopperstad is also entitled to

qualified immunity, as plaintiffs introduced no facts showing Hopperstad was personally involved in denying Rogers his constitutional rights, that he implemented a policy that denied Rogers his rights, or that he otherwise acted in his official or individual roles with deliberate indifference towards Rogers' rights.

D. *Weighing of evidence*

Plaintiffs contend the trial court improperly weighed the evidence when it denied their motion for summary judgment. They cite only one example they say supports their contention. The trial court found Rogers was restrained at County General because he was a flight risk. However, the County General physician testified Rogers was restrained because he was a flight risk and a danger to himself and others. The trial court's omission of the other details does not establish the court improperly weighed the evidence. The point is irrelevant, as the undisputed evidence of what transpired after Rogers left County General established Dr. Gill exercised her professional judgment in all respects.

For all of the above reasons, we affirm the trial court's grant of summary judgment.

III

Motion for New Trial

Plaintiffs contend the trial court erred in denying its motion for new trial. They argue the court should have granted the motion on the basis of newly discovered evidence, irregularities in the proceeding, and errors of law. We disagree.

A. *Additional background information*

Defendants filed their motion for summary judgment on June 15, 2010. Plaintiffs filed their opposition on November 19, 2010. In the intervening months, plaintiffs deposed 10 witnesses. As stated above, on May 17, 2011, the trial court granted the motion for summary adjudication as to plaintiffs' ADA and Rehabilitation Act cause of

action but denied it as to their section 1983 causes of action. Defendants filed their motion for reconsideration on May 27, 2011. The trial court granted it on July 8, 2011.

After the trial court granted reconsideration but before it granted the motion for summary judgment, the parties engaged in two discovery disputes concurrently. Both arose from two sets of special interrogatories plaintiffs served on defendants during this time period. The first dispute concerned a set of interrogatories (set No. 2) served on May 24, 2011. By these interrogatories, plaintiffs sought to know the number of patients who had been admitted to the PHF from January 1, 2001, through March 23, 2006; how many of those patients had been classified as a severe risk of committing suicide; the number of times additional staff members were assigned to attend to those patients; and the costs the PHF incurred from assigning additional staff to severe-risk patients. Plaintiffs also served a corresponding document request.

Defendants objected to the interrogatories and document requests, and they refused to comply. On July 7, 2011, plaintiffs filed a motion to compel and for sanctions. The trial court granted plaintiffs' motion on August 10, 2011, and imposed monetary sanctions against defendants.

After another demand by plaintiffs, defendants, on September 2, 2011, served supplemental responses to the interrogatories and request for documents. They said they could not reasonably provide the information plaintiffs sought, and there were no responsive documents. On September 21, 2011, plaintiffs filed another motion to compel and for sanctions.

The second concurrent discovery dispute arose from a set of special interrogatories plaintiffs served on defendants on June 17, 2011. These interrogatories (set No. 3) sought to know the telephone number Stafford used on March 20, 2006, to call Dr. Hart at his home, and the number Dr. Hart used to receive Stafford's call. Defendants objected to these interrogatories, stating they had no detailed telephone records for March 20 and the request violated Dr. Hart's right of privacy. After further demand by

plaintiffs, defendants responded on August 17, 2011. They provided four telephone numbers that were connected to the PHF shift charge's phone and, because Dr. Hart was called "at home," Dr. Hart's home phone number.

On September 9, 2011, plaintiffs served a business records subpoena on AT&T for copies of records documenting telephone calls between Stafford's numbers at the PHF and Dr. Hart's home phone number during the early morning hours of March 20, 2006.

Thus, as of October 4, 2011, plaintiffs' second motion to compel and for sanctions to receive information on the PHF patients designated as severe risk was pending, and plaintiffs had not yet received documents in response to their subpoena against AT&T for phone records. On October 4, the trial court granted defendants' motion for summary judgment, 16 months after defendants had filed it.

After receiving the order granting summary judgment, plaintiffs asked the discovery referee to rule on their motion for sanctions. The trial court, however, advised the referee to stop work on the discovery matters. Defendants also objected to Compex Legal Services, the company that would copy and produce the requested telephone records, and asked it to stop copying the records because the case had been dismissed.

On October 14, 2011, plaintiffs filed a motion for reconsideration. Six days later, on October 20, 2011, the custodian of records at AT&T informed plaintiffs through Compex Legal Services that no documents responded to the subpoena. AT&T found no calls were made from the PHF shift charge's phone numbers to Dr. Hart's home phone number between the hours of 1:00 a.m. and 3:00 a.m. on March 20, 2006. Plaintiffs submitted this evidence to the court as part of their motion for reconsideration.

Meanwhile, the trial court entered judgment against plaintiffs on October 17, 2011. Defendants filed a notice of entry of judgment on October 26, 2011.

Plaintiffs filed a motion for new trial. They based their motion on the following grounds: (1) irregularity in the court's proceedings; (2) irregularities by the defendants; (3) improper orders by the court; (4) abuse of discretion by the court; (5) newly

discovered evidence purporting to show that no one from the PHF called Dr. Hart on the morning of March 20, 2006; (6) the judgment was against the law; and (7) error in the law. (Code Civ. Proc., § 657, subds. 1, 4, 6 & 7.) Plaintiff also moved for sanctions. Plaintiffs' counsel, Jeffrey A. Silva, submitted a declaration supporting the motion for new trial. His declaration included most of the evidence plaintiffs submitted to support the motion.

Opposing the motion for new trial, defendants submitted a declaration by Dr. Hart. Dr. Hart testified he maintained multiple phones by which the PHF could contact him, including two cell phones, two separate home phone numbers, and a pager. He also testified he had in fact received a call from Stafford the morning of March 20, 2006. When he was asked to provide counsel with the number of the phone on which he received Stafford's call, he in good faith believed he had received it on one of his home phones but also stated it was possible he was contacted via another phone or by pager.

As part of opposing the motion for new trial, defendants sought sanctions. It also objected to Silva's declaration and the evidence submitted under it, and it moved to strike it.

On reply, plaintiffs objected to Dr. Hart's declaration.

The trial court denied the motion for new trial and awarded no sanctions. In reaching its decision, the court overruled plaintiffs' objection to Dr. Hart's declaration, but it sustained defendants' objection to, and struck, Silva's declaration.

B. *Analysis*

A motion for a new trial may be made following an order granting summary judgment. (*Aguilar v. Atlantic Richfield Co., supra*, 25 Cal.4th at p. 858.) On review of an order denying a new trial, we have the obligation to review "the entire record, including the evidence, so as to make an independent determination whether the error [if any] was prejudicial." (Cal. Const., art. VI, § 13; *Hasson v. Ford Motor Co.* (1982) 32

Cal.3d 388, 417, fn. 10.) We review the court's ruling as to each ground for new trial plaintiffs raised.

1. *Striking of Silva's declaration and attached documents*

Plaintiffs contend the trial court erred when it struck their attorney's declaration supporting the motion for new trial and the documentary evidence attached to it. The court did not abuse its discretion. Silva's declaration is filled with legal argument. For example, he states the alleged irregularities, errors, and abuses of discretion "mandate the granting of [a] motion for new trial"; "[t]he record reflects that Mr. Garrett lacks personal knowledge and was not competent to testify"; "[i]nstead of properly responding to the legitimate discovery of Plaintiffs on material issues to the case, Defendant County filed blanket objections . . . in response to the proper discovery of Plaintiffs claiming false burdens, false expense and false privacy issues"; "Defendants' willful misconduct was again one of simply stonewalling, disobeying this Court's Order, gamesmanship and misuse of the discovery process undertaken to prejudice Plaintiffs, with summary judgment motion pending, for delay and to prevent Plaintiffs from having a fair trial"; and "[t]here is newly discovered evidence, material for Plaintiffs which they could not have discovered and produced in opposition to the summary judgment motion, which will change the outcome of the trial (summary judgment)." The declaration continues in this fashion.

The practice of attorneys using their declarations to make arguments "makes a mockery of the requirement that declarations be supported by statements made under penalty of perjury. The proper place for argument is in points and authorities, not declarations." (*In re Marriage of Heggie* (2002) 99 Cal.App.4th 28, 30, fn. 3.) The trial court did not abuse its discretion by striking Silva's declaration on this basis.

2. *Newly discovered evidence and abuse of process*

Plaintiffs argue the evidence they submitted from AT&T showing no calls were made between the PHF and Dr. Hart's phone number was newly discovered evidence

necessitating a new trial. They claim the evidence shows Stafford never called Dr. Hart; Dr. Hart's testimony that he received a call and designated Rogers as a moderate suicide risk was false; Stafford falsified the doctor's order for Rogers and designated him as moderate risk based on the unwritten policy of the PHF requiring her to do so; and Dr. Gill, relying upon the false order by Dr. Hart and aware of the unwritten policy, designated Rogers as a moderate risk on those grounds. They also claim defendants abused the discovery process by requesting Compex Legal Services not to produce any documents from AT&T.

Plaintiffs also contend defendants' failure to comply with the interrogatories requesting information on the number of patients who are designated as severe risk and the operating costs resulting from those designations was new evidence justifying a new trial. Plaintiffs assert the new evidence was the lack of objective data answering the interrogatories. They also claim defendants abused the discovery process when they refused to comply with the interrogatories and, after being sanctioned, provided evasive responses.

We conclude the phone call evidence and the lack of answers to the interrogatories do not justify a new trial.

To receive a new trial based on new evidence, plaintiffs must satisfy three requirements. First, they must show the evidence was newly discovered. It must be evidence that was not known, and could not have reasonably been known, at the time of trial. (*Santillan v. Roman Catholic Bishop of Fresno* (2012) 202 Cal.App.4th 708, 730-731.) Second, the evidence must be material to plaintiffs' case. "Material" in this context means likely to produce a different result. (*Id.* at pp. 727-728.) Third, plaintiffs must show they exercised reasonable diligence to discover and produce the evidence at trial. (*Ibid*., Code Civ. Proc., § 657, subd. 4.)

Here, the evidence proffered by plaintiffs is not material, or in other words, not likely to produce a different result. Plaintiffs offer no evidence—they offer much

speculation, but no evidence—opposing Dr. Gill's testimony that she designated Rogers as a moderate risk based on her professional judgment. Thus, whether Stafford called Dr. Hart became irrelevant once Dr. Gill personally examined Rogers and determined he was a moderate risk. Submitting evidence showing Stafford may not have called Dr. Hart adds nothing to plaintiffs' case. Similarly, whether the PHF rarely designated patients as a severe risk of suicide also became irrelevant when Dr. Gill personally examined Rogers and determined he was a moderate risk based on his personal situation at the time of the interview and her professional judgment. The abuse of process arguments also fail for the same reasons.

3. *Overruling plaintiffs' objection to Dr. Hart's declaration*

Plaintiffs contend the court erred by overruling their objections to Dr. Hart's declaration submitted in opposition to their motion for new trial. They argue the declaration was irrelevant and Dr. Hart's testimony was speculation. Also, they claim defendants were bound by their discovery responses when they "unambiguous[ly]" gave the specific number Hart used to receive the call.

The trial court did not abuse its discretion. Dr. Hart's testimony was relevant. Even if the court erred, the error was not prejudicial. The overriding issue was whether Dr. Gill exercised professional responsibility, not whether Dr. Hart did, and the undisputed evidence shows she did.

4. *Irregularities and errors of law*

The remainder of plaintiffs' arguments center on the merits of the trial court's rulings and the alleged misuse of the discovery process by defendants. We have already sustained the trial court's rulings and need not readdress them here. As to discovery misuse, we again note the discovery plaintiffs contested concerned evidence that had little bearing on whether Dr. Gill exercised her professional judgment in designating Rogers as a moderate risk of suicide. Any discovery process misuse or erroneous discovery order was harmless.

The trial court did not abuse its discretion by denying plaintiffs' motion for new trial.

DISPOSITION

The judgment is affirmed. Costs on appeal are awarded to defendants. (Cal. Rules of Court, rule 8.278(a).)

NICHOLSON, Acting P. J.

We concur:

HULL, J.

MURRAY, J.